Name: _____

Chart No: _____

Birth Date: _____

DENTAL HEALTH HISTORY

In the following questions, circle **Yes** or **No,** whichever applies. Your answers will be considered confidential.

1. Do you **(Patient)** have or have you **(Patient)** had any of the following:

Rheumatic Fever or Heart Murmur	Yes	No	Neurological Problems	Yes	No
Heart Trouble or Shortness of Breath	Yes	No	Tuberculosis (TB) or Persistent Cough	Yes	No
High or Low Blood Pressure	Yes	No	Diabetes or Excessive Thirst	Yes	No
Fainting or Dizzy Spells	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Kidney Problems or Excessive Urination	Yes	No
Anemia or Blood Problems	Yes	No	Liver Problems or Hepatitis	Yes	No
Sickle Cell Anemia	Yes	No	Sexually Transmitted Disease (STD)	Yes	No
Excessive Bleeding or Bruise Easily	Yes	No	AIDS/ARC/HIV Positive	Yes	No
Blood Transfusions	Yes	No	Cancer	Yes	No
Allergies or Skin Rash	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Trimester 1 2 3		
Thyroid Problems	Yes	No	Painful or Swollen Joints	Yes	No
Emotional Problems	Yes	No	Smoke, Smokeless Tobacco	Yes	No
Other_____					

2. **A**re you (**Patient)** currently under the care of a physician (doctor)? Yes No
   If yes, list name of doctor_____

3. Have you (**Patient)** been hospitalized in the last 2 years? Yes No
   If yes, why?_____

4. Are you (**Patient)** currently taking any medications, pills, or drugs? Yes No
   If yes, list._____

5. Are you (**Patient)** allergic to or have you ever experienced any ill effect from a local anesthetic (Novocain), Penicillin, or any other drugs/pills? i.e., rash, itching or fainting. Yes No
   If yes, describe_____

6. Have you (**Patient)** ever experienced any unfavorable reaction from a previous dental treatment? Yes No
   If yes, describe_____

7. Are you (**patient)** currently having any dental pain or problem? Yes No
   If yes, describe_____

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient _____ Date_____
(If patient is a child, parent or legal guardian must sign) Relationship_____

Comments by Dentist:_____

_____

_____

Signature of Dentist_____ Date_____

Name: _____

Chart No: _____

Birth Date: _____

DENTAL HEALTH HISTORY

Dental Health History Review/Update:

1. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____

2. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____

3. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____

4. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____

5. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____

6. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____

7. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____

8. Comments:
Patient:_____
_____
Dentist:_____
_____

Date:_____ Patient's Signature_____ Dentist's Signature_____